Ensuring appropriate polypharmacy in patients with increasing frailty or moving towards end of life care

It is essential to optimise medicines to ensure safe prescribing and appropriate polypharmacy for patients with increasing frailty or moving towards end of life. Medicines that should usually be continued and those with increased potential to cause harm[1,2] are highlighted in the full bulletin with evidence-based tools to help the review process.[3-6] Actions that health care professionals can take to support these patients are suggested.

Key recommendations

- Older people should be assessed for frailty at all encounters with health or social care professionals as frailty can change over time.
- Consider frailty in younger patients, particularly those with multiple co-morbidities.
- Care is needed in prescribing for people with increasing frailty due to potential physiological changes, leading to a decrease in the function of various organ systems that may adversely affect the metabolism of medicines.
- Think about the harm to benefit profile of each medicine.
- Conduct personalised medication reviews more regularly for patients with frailty, using one of the evidence-based review tools.[3-6]
- Ensure appropriate polypharmacy at end of life.
- Practices should have a palliative care register that includes patients with increasing frailty.[7]
- One clinician, or one clinical team, should take responsibility for a patient's medicines.[8]

Definition of frailty

Individuals of any age who present with multiple co-morbidities, significant impairment in day-to-day living with a deteriorating functional score, plus a combination of at least three of the following symptoms: weakness, slow walking speed, significant unintended weight loss, exhaustion, low physical activity or depression are described as having frailty.[9]

Identifying patients moving towards end of life

The simple question: "Would I be surprised if this person were to die in the next 12 months?" (known as 'the surprise question') is accurate seven times out of ten.[9]

Additional resources available: https://www.prescqipp.info/resources/category/299-polypharmacy-frailty

Bulletin

Patient information leaflet, case studies

Costs and savings

Some of the current national problems are set out below.

5-8% of unplanned, emergency hospital admissions are due to adverse reactions (ADR) to medicines; up to two thirds of these are preventable.[10] In 2007 the National Patient Safety Agency (NPSA) estimated the cost of medication safety incidents to the NHS as £770 million.[11]

ADRs result in 20% of patients being re-admitted to hospital within one year of discharge from their index admission; up to 50% of the ADRs were possibly avoidable.[12]

It is estimated that 30-50% of medicines prescribed for long term conditions are not taken as anticipated, resulting in the loss in health gain of billions of pounds.[13]

Ten days after starting a new medicine, 30% of patients are already non-compliant, of these 55% don't realise they are not taking their medicines correctly. Only 16% of patients who are prescribed a new medicine are taking it as prescribed, experiencing no problems and receiving as much information as they need.[14]

In primary care, wasted medicines are estimated to be at least £300 million per year, of which half is avoidable.[15,16]

A patient stabilised on fewer medicines following a medication review will potentially require less contact with health professionals and fewer unscheduled hospital admissions due to ADRs.[17]

Related PrescQIPP resources

Improving Medicines and Polypharmacy Appropriateness Clinical Tool (IMPACT), March 2016. https://www.prescqipp.info/polypharmacy-impact/category/272-polypharmacy-impact

Care homes webkit: https://www.prescqipp.info/carehomes

Polypharmacy and Deprescribing webkit: https://www.prescqipp.info/polypharmacy-deprescribing-webkit

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